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Nos. 93-1408, 93-1414, 93-1415

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

MARIO M. CUOMO, in his official Capacity as Governor of the State of New York, et al.

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST, NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE and HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIANS HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Respondents.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

RESPONDENTS' SUPPLEMENTAL BRIEF IN OPPOSITION TO PETITIONS FOR A WRIT OF CERTIORARI

HAROLD N. ISELIN*
WENDY L. RAVITZ
COUCH, WHITE, BRENNER, HOWARD & FEIGENBAUM
Attorneys for Respondents New York State Health Maintenance Organization Conference, Capital District Physicians Health Plan, Inc., Choicecare Long Island, Inc., Health Services Medical Corporation of Central New York, Inc., Independent Health Association, Inc., Mid-Hudson Health Plan, Inc., MVP Health Plan, Inc., Oxford Health Plans, Inc., Physicians Health Services of New York, Inc., Preferred Care, Inc., Travelers Health Network of New York, Inc., U.S. Healthcare, Inc. and Wellcare of New York, Inc.
540 Broadway
P.O. Box 22222
Albany, New York 12201-2222
(518) 426-4600

*Counsel of Record

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12 pp

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Nos. 93-1408, 93-1414, 93-1415

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Preliminary Statement

This brief is submitted, pursuant to Supreme Court Rule 15.7, on behalf of the respondents the New York State Health Maintenance Organization Conference and twelve health maintenance organizations (collectively referred to as the "HMOs")[1] in response to the *amicus curiae* brief of the United States Solicitor General urging that the petitions for certiorari regarding the three surcharges be granted in this action. Because the HMOs are subject only to the 9% assessment, this brief addresses the preemption of only that assessment.

By urging the Court to grant certiorari on the three surcharges, without analyzing the critical distinctions between them, the Solicitor General has obscured the fact that the 9% assessment relates directly to ERISA plans and is therefore preempted by ERISA. The differences between the 9% and other assessments, which the Solicitor General has attempted to sweep under the rug, undermine not only the merits of the Solicitor General's preemption analysis, but also his discussion of the purported conflict between the Second Circuit's decision in this case and the Third Circuit's decision in *United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S.Ct. 382 (1993) ("*United Wire*").

Equally unavailing is the Solicitor General's suggestion that if this Court ultimately affirms the Second Circuit's decision that the 9% assessment "relates to" employee benefit plans, the Court should remand to the Court of Appeals for a determination of whether the assessment falls within the insurance savings clause. Such a suggestion is not only premature, but also is unsupported by the record. Petitioners did not argue below, and do not appear to be arguing here, that the 9% assessment is saved from preemption by the insurance savings clause.

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[1] A list of parent and subsidiary companies, pursuant to Supreme Court Rule 29.1, previously was submitted to the Court in Respondents' Brief in Opposition to Petitions for a Writ of Certiorari, dated April 8, 1994.

Finally, the Solicitor General's statement of the case is factually incorrect with respect to its discussion of the legislative requirements imposed on the Blue Cross/Blue Shield organizations (the "Blues"). Contrary to the Solicitor General's representation, the Blues are not "required" to engage in open enrollment (see *Amicus* Mem. at 3)[2]. While certain Blue Cross/Blue Shield companies might offer insurance to all categories of insureds, only HMOs are statutorily required to open enroll in all markets. Similarly, only HMOs community rate across the board. In this context, the Solicitor General's statement that the Blues are the "'insurer of last resort' for high-risk individuals" (see *Amicus* Mem. at 3), is incomplete, if not misleading. Because HMOs are required to accept all persons requesting coverage, they are at a risk equal to, if not greater than, the Blues.

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[2] References herein to the brief of the Solicitor General shall be designated as "*Amicus* Mem. at __".

ARGUMENT

1. THERE IS NO CIRCUIT CONFLICT AS TO THE 9% ASSESSMENT

The New Jersey statute at issue in *United Wire* involved a surcharge added to the DRG rate to cover bad debt expenses and the cost of uncompensated care provided to the indigent. Regardless of whether a conflict may exist between the Third Circuit and the Second Circuit's decision regarding the 11% and 13% surcharges, there is no conflict regarding the 9% assessment. Unlike the surcharges at issue in *United Wire*, the 9% assessment has nothing whatsoever to do with hospital reimbursement or the bad debt and charity pool.

The 9% assessment imposes a penalty, calculated at 9% of an HMO's aggregate cost of inpatient hospitalization, on HMOs that are unable to enroll a certain target number of Medicaid subscribers. The 9% assessment is not an increase in the DRG rate paid to hospitals, nor do any of the funds raised by the assessment ever reach the hospital providing the services. The funds are directly paid to a State-designated pool administrator and then forwarded to the State's General Fund. In short, the 9% assessment has nothing whatsoever to do with the regulation of hospital care in New York State.

The petitioners and Solicitor General concede that the purpose of the 9% assessment is to bolster the State's Medicaid managed care program by inducing HMOs to shoulder the burden of a larger percentage of the Medicaid population. The fact that the State chose to do this by imposing a penalty calculated as a percentage of the HMOs' hospitalization costs was purely arbitrary. The State could just as easily have chosen a different penalty to achieve the same result.

Thus, contrary to the Solicitor General's allegation, the 9% assessment is not a law of general application designed to vary the cost of hospital services for various payors. (See *Amicus* Mem. at 11). The 9% assessment has nothing to do with hospital rates, is directed solely at HMOs and may be avoided entirely if the HMOs meets their Medicaid targets.

2. THE 9% ASSESSMENT "RELATES TO" ERISA PLANS

Although the Government argued below that the surcharges related to ERISA plans because they disparately applied to such plans and were intended to and did affect plan behavior, it inexplicably reverses its position here and now argues that there is no connection between the 9% assessment and ERISA plans. The Solicitor General's attempt to discount the effect of the 9% assessment by categorizing it now as a "generally applicable state law[] that ha[s] only an indirect economic effect on ERISA plans" (see *Amicus* Mem. at 9) is without merit.

It is difficult to comprehend how a surcharge specifically designed to raise the cost of health care coverage provided by an HMO unless specified Medicaid targets are met is a law of general applicability with *only* an indirect economic impact on ERISA plans. First, the 9% assessment applies only to HMOs; it does not apply to insurance companies or other non-HMO Medicaid providers. Second, the assessment is levied only against those HMOs that fail to meet their Medicaid targets. Those that do meet the targets avoid the assessment entirely. Third, the vast majority of the HMOs' subscribers are beneficiaries of ERISA plans and, as the Second Circuit noted, eighty-eight percent of non-elderly Americans receive some form of private health care coverage through ERISA plans. (A-6)[3]. Thus, the only reason the 9% assessment functions as a meaningful penalty is because of the overwhelming presence of ERISA plans in HMO systems.

The Second Circuit correctly concluded that the 9% assessment forces HMOs either to raise the cost of coverage or to reduce benefits. An HMO that is unable to meet its Medicaid enrollment targets has no choice but to pass the increase on to its subscribers because the only other alternative would be for the HMO to expend reserves — a practice that is not only irresponsible but ultimately unavailing since the surcharge payments would quickly exhaust reserves leaving the HMO bankrupt.

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[3] References herein to the Appendix shall be designated as "A-__".

Thus, the 9% assessment clearly has the requisite connection with ERISA plans.

However, the 9% assessment strikes even more directly at ERISA plans because, in the face of higher costs or reduced benefits, ERISA plans may switch from an HMO not meeting the relevant targets to a different type of coverage. Ironically, in the court below, the Government relied on this very type of market disruption to support its position that the 9% assessment related to ERISA plans. There, the Government asserted that "the surcharges have a connection with plans because their purpose and effect is to alter plan behavior. . . ." Brief for the Secretary of Labor as *Amicus Curiae* at 12, *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708 (2d Cir. 1994) (Nos. 93-7132, 7134, 7148).

Contrary to the Solicitor General's suggestion here that the assessment's only impact is "indirect and solely economic" (*Amicus* Mem. at 14), the assessment actually has a direct and disruptive effect on the choices ERISA plans make regarding health care coverage. Because HMOs actually provide care, an ERISA plan cannot select alternative coverage without, in many cases, disrupting the case that is being provided to its employees. This is particularly true if an ERISA plan switches from the comprehensive, coordinated care approach of an HMO to the fragmented approach of fee-for-service indemnity insurance.

The Solicitor General also argues that the requisite connection between the surcharges and ERISA plans is lacking because the surcharges are laws of "general applicability" whose only direct impact is on the HMOs, not the plans themselves. In *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994) ("*NYSA-ILA*"), the Second Circuit noted:

> The [state tax] does *not* apply broadly to every sector of society in New York .... Rather, the [tax] targets *only* the health care industry. Because this industry is, by definition, the realm where ERISA welfare plans must operate, the [tax] was bound to affect them. In a case such as the present one where the plan has chosen to

> provide medical benefits through self-run medical centers, the [tax] operates as an immediate tax on payments and contributions which were intended to pay for participants' medical benefits.

NYSA-ILA, 27 F.3d at 827 (emphasis added).

The surcharges here are targeted even more narrowly than the tax in *NYSA-ILA*. The 9% assessment does not apply broadly to all sectors of New York society, or even to all sectors of the health care industry or all categories of Medicaid providers. Instead, it is aimed solely at HMO-provided health care benefits.

3. THE ISSUE OF WHETHER THE 9% ASSESSMENT MIGHT FALL WITHIN THE INSURANCE SAVINGS CLAUSE HAS NOT BEEN RAISED BY PETITIONERS AND SHOULD NOT BE ADDRESSED HERE

In analyzing the question of whether the surcharges are preserved by the insurance savings clause, the Second Circuit concluded, as a matter of law, that HMOs do not engage in the business of insurance. Accordingly, the Second Circuit also adopted the conclusion of the district court that the 9% assessment does not fall within the scope of the insurance savings clause. (A-26-27 n.5; A-29 n.6). Recognizing that the 9% assessment was designed solely to induce HMO enrollment in Medicaid managed care programs and to raise money for the State treasury, the petitioners did not assert that the district court erred in its conclusion that the 9% assessment does not fall within the savings clause, nor do they do so here. Indeed, only the Government, both below and before this Court, contends that this is an issue. Here, the Government argues that if this Court ultimately determines that the 9% assessment does relate to ERISA plans, it must remand the issue of whether the assessment falls within the insurance savings clause to the court of appeals. (*Amicus* Mem. at 17 n. 8).

Even if this issue had been raised on appeal, it would have no merit. The record is replete with references to the fact that

the 9% assessment is a device designed to achieve certain Medicaid enrollment objectives and to raise funds for the state treasury. Indeed, the State, which was the sole architect of the law, has never contended differently. The 9% assessment has nothing whatsoever to do with the business of insurance, hospital reimbursement or the bad debt and charity pool. It is designed only to lessen the State's burden under the Medicaid program — a program enforced under New York's Social Services Law, not the Insurance Law. Thus, there is no basis for the Court to remand the issue.

CONCLUSION

For the foregoing reasons, the petitions for a writ of certiorari should be denied.

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September 27, 1994

Respectfully submitted,

HAROLD N. ISELIN*
WENDY L. RAVITZ

COUCH, WHITE, BRENNER, HOWARD
& FEIGENBAUM
540 Broadway
P.O. Box 22222
Albany, New York 12201-2222
Telephone: (518) 426-4600

Attorneys for Respondents
New York State Health Maintenance Organization Conference, Capital District Physicans' Health Plan, Inc., Choicecare Long Island, Inc., Health Services Medical Corporation of Central New York, Inc., Independent Health Association, Inc., Mid-Hudson Health Plan, Inc., MVP Health Plan, Inc., Oxford Health Plans, Inc., Physicians Health Services of New York, Inc., Preferred Care, Inc., Travelers Health Network of New York, Inc., U.S. Healthcare, Inc. and Wellcare of New York, Inc.

* *Counsel of Record*